MSS Prenatal Screening Guide

Date: _____ Time visit started:_____☐AM ☐PM Time visit ended _____☐AM ☐PM Home visit/ Office visit/Alternate site

Client name: _____ Date of birth: ___/___/___ Age at conception: _____

Race/Ethnicity/Tribal affiliation: _____ EDD ___/___/____ Delivery Date: ___/___/____

Education Level: _____ Currently in school? Y or N

Living/housing situation: _____ Currently working? Y or N _____

Primary language spoken: _____ Language barriers: Y or N _____

Prenatal medical provider: _____ Medical provider's telephone # _____

QUESTIONS		RISK/PURPOSE **BOLD =** Targeted Risk Factors
I am going to ask some questions to better help us support you during this pregnancy. This information will be kept confidential. Please let me know if you have any concerns or questions as we go along.		Rapport building
1.	How is your pregnancy going? How are you feeling? • How are you feeling about being pregnant? • Is this good timing for your pregnancy? ☐ Y or ☐ N Tell me more. Have you had any changes in your appetite or sleep habits? ☐ Y or ☐ N (If yes) What? _____	Rapport building Check for any warning signs Adjustment to pregnancy ☐ If client is showing any **signs of depression** she will need further screening
2.	Have you seen a medical provider for this pregnancy? ☐ Y or ☐ N (If yes) When did you first see your medical provider?_____ When is your next appointment?_____ (If no) Why don't you have a medical provider? _____ (If no medical provider skip to Q #4)	Referral/link to medical care **Prenatal medical care:** ☐ **Greater than or equal to (≥) 14 and less than (<) 24 weeks and no prenatal care started at time of screening** ☐ **Greater than or equal to (≥) 24 weeks gestation and no prenatal care started at time of screening** ☐ **Started prenatal care during third trimester (greater than or equal to (≥) 24 weeks gestation)**
3.	(If seen by a medical provider) Has your medical provider told you about any health or medical concerns with your current pregnancy, such as high blood pressure, gestational diabetes, preterm labor, or pregnant with two or more babies?	☐ **Gestational Diabetes** ☐ **Hypertension during pregnancy (PIH/Gestational Hypertension)** ☐ **Preterm labor** ☐ **Prescribed bed rest due to conditions that could lead to preterm birth, i.e. placenta previa or placenta abruption** ☐ **Multiple Gestation**
4.	How much did you weigh before this pregnancy? _____lb Have you had your weight checked recently?_____lb Date : _____ Height:_____(feet and inches) • Please document how you obtained the client's weight (agency scale, client reported, another source-medical provider, or WIC). • MSS providers will need to determine the client pre-pregnancy BMI and pregnancy weight gain.	**Pre-pregnancy BMI:** ☐ **Less than (<) 18.5 BMI** ☐ **25 to 29.9 BMI** ☐ **Greater than or equal to (≥) 30 BMI**

	QUESTIONS	RISK/PURPOSE **BOLD =** Targeted Risk Factors
5.	Is this your first pregnancy? ☐ Y or ☐ N (If yes) skip to Q #8 (If no) • How many times have you been pregnant? _____ • Have any of them been miscarriages, stillbirth or early infant death? ☐ Y or ☐ N (If yes) How many and when?_____ • When did your last pregnancy end? _____ • Did you have fertility treatment with this pregnancy? ☐ Y or ☐ N	☐ **35 years of age or older and this is the first pregnancy** ☐ **Inter-pregnancy interval less than 9 months from end of last pregnancy (including miscarriages or terminations)** ☐ **Fetal death history (greater than (>) 20 weeks gestation)** ☐ **35 years of age or older at the time of conception and used ART**
6.	(If any live births) Did your baby (babies) have any health or medical problems at birth? If yes, what were they? _____ • How much did your last baby (babies) weigh at birth? _____ • How many weeks pregnant were you at delivery?_____weeks • Did you deliver any of your babies before 37 weeks gestation or did any of the babies weigh less than 5 pounds 8 ounces? ☐ Y or ☐ N (If yes) How many? ____	☐ **Prior LBW (less than (<) 5# 8 oz) and/or Premature Infant (less than (<) 37 weeks)**
7.	Did you have gestational diabetes, high blood pressure, depression, or postpartum depression with your last pregnancy? ☐ Y or ☐ N (If yes) Tell me more. _____	☐ **History Gestational Diabetes with last pregnancy** ☐ **History of Gestational Hypertension** ☐ **History Perinatal Mood Disorder or postpartum depression with last pregnancy**
8.	Do you have any health problems or medical conditions not related to pregnancy? ☐ Y or ☐ N (If yes) Tell me more. Examples- Hypertension, diabetes, treatment of mental health issues, etc.? _____	☐ **Chronic Hypertension** ☐ **Diabetes- type 1 or 2** ☐ **Perinatal Mood Disorders/ Depression** ☐ **Severe Mental Illness**
9.	Are you currently taking any prescribed medications, over the counter medications, supplements, vitamins, and/or home remedies? ☐ Y or ☐ N (If yes) What are they and how much/often do you take them? _____ (If yes and has prenatal care provider) Have you discussed taking these during pregnancy with your prenatal care provider? ☐ Y or ☐ N (If no) Why not? _____	☐ **Medications related to psychiatric issues, diabetes, and hypertension.** ☐ **Non-prescriptive use of prescription drugs** Supplements, prescription drugs Prenatal vitamins/folic acid/iron
10.	When was the last time you saw a dentist? _____ • Do you have any problems with your teeth or gums that affect how you eat? ☐ Y or ☐ N (If yes) What? _____	Referral to dental care
11.	Do you ever run out of food before the end of the month or cut down on the amount you eat to feed others? ☐ Y or ☐ N (If yes) Tell me more. _____ Depending on feedback follow up with: • Are you currently on WIC? ☐ Y or ☐ N • Basic Food Program (food stamps)? ☐ Y or ☐ N • Are you aware of other food programs in the area? ☐ Y or ☐ N	☐ **Food Insecurity** Referral to WIC/Basic Food Program (food stamps) and/or food banks

Staff Signature: _____ Date: _____ Client ID #:_____

	QUESTIONS	RISK/PURPOSE **BOLD =** Targeted Risk Factors
The following questions we ask everyone, because they have to do with health and safety.		Transition
12.	Have you ever smoked or used tobacco or nicotine products? ☐ Y or ☐ N (If no) skip to Q #13 (If yes) Did you use during the three months before you became pregnant? ☐ Y or ☐ N • Are you currently using tobacco/nicotine? ☐ Y or ☐ N (If no) skip to Q #13 (If yes) Are you trying to quit? ☐ Y or ☐ N Tell me more. • Are you interested in getting help to quit? ☐ Y or ☐ N	☐ **Current Maternal Tobacco/Nicotine Use** ☐ **Quit tobacco/nicotine 3months prior to pregnancy or at time of pregnancy diagnosis**
13.	Does anyone smoke inside your home and/or car? ☐ Y or ☐ N	Basic health message- Second hand smoke
14.	When was the last time you drank alcohol? _____ • Are you currently drinking alcohol? ☐ Y or ☐ N (If no) skip to Q #15 • Are you trying to stop? ☐ Y or ☐ N Tell me more._____ • Are you interested in getting help to stop? ☐ Y or ☐ N	☐ **Alcohol use/Abuse- See definitions**
15.	When was the last time you used illicit drugs? (If never) skip to Q #16 _____ • Are you currently using drugs? ☐ Y or ☐ N (If no) skip to Q #16 • Are you trying to stop? ☐ Y or ☐ N Tell me more._____ • Are you interested in getting help to stop? ☐ Y or ☐ N	☐ **Mental Health**
16.	In the last year, has your partner or FOB physically threatened or tried to hurt you? ☐ Y or ☐ N (If yes) Tell me more. _____ _____	☐ **Intimate partner violence within last year**
17.	In the last month, have you felt down, depressed, or hopeless? ☐ Y or ☐ N (If yes) Client needs standardized depression screening tool completed.	☐ **Mental Health**
18.	Have you ever received mental health services or counseling? ☐ Y or ☐ N (If yes) Client needs clinical assessment.	☐ **Mental Health**
19.	Who can you count on for help/support during this pregnancy? Who can you talk to about stressful things in your life?	Social Support
20.	Is there any information or resources you would like us to help you with during this pregnancy? ☐ Y or ☐ N (If yes) Client wants help with _____ Are you having any problems with transportation? ☐ Y or ☐ N	Basic referrals- housing, transportation, CBE Health messages Client's needs
Screener, document whether the client discloses or shows signs that she is severely developmentally disabled in a way that may impact her ability to take care of herself during the pregnancy or take care of a child.		☐ **Developmental Disability-** women with severe developmental disability which impacts the woman's ability to take care of herself during the pregnancy or her infant postpartum

Was there anyone at the appointment who prevented you from asking any questions or may have influenced the client's responses?

☐ Y or ☐ N (If yes) Describe: _____

Client Name: _____ Client I.D. number_____

Staff Signature: _____ Date: _____

Revised 05.19.2014